Autism Coverage Fund
FAQ – Responses in BOLD
March 26, 2013 (Updated)

Autism Coverage Fund Questions

1. Who is eligible to participate in this program and seek reimbursement for claims from the Autism Coverage Fund?

   Commercial and non-profit health insurance carriers and third party administrators (TPA) are eligible to seek reimbursement from this Fund. For more information refer to Eligibility Requirements.

2. What is the frequency in which a carrier or third party administrator (TPA) may submit requests for reimbursements?

   Once a month.

3. When will the first submission of a claim(s) be accepted for reimbursement?

   Public Acts 99 and 100 of 2012 will take effect on October 15, 2012 whereby health insurance carriers will be required to offer an autism benefit for the diagnosis and treatment of autism spectrum disorders (ASD). Many health insurance policies may not be effective until after this date. Department of Financial Services (DIFS) will accept claims for reimbursement starting on October 15, 2012 for ASD diagnosis and treatment services provided on or after October 15, 2012. Any ASD services provided prior to October 15, 2012 will not be eligible for reimbursement from the Autism Coverage Reimbursement Fund.

4. If multiple health plans submit reimbursement claims on the same date, how will the fund determine in what order plans will get reimbursed?

   As requests are submitted, the appropriate DIFS administrator will receive a notification which will be date and time stamped. In addition, when the carriers or third party administrators (TPA) complete the certification form and submit with the claims data, this will also be date and time stamped. These time verifications will allow DIFS to issue payments in the order by which they are received.

5. What is the expected lag time for the reimbursement payment to the health plan or TPA?

   If there are no issues with the reimbursement request and processing, it could take 2 to 7 business days from when DIFS and the Department of Treasury receives the reimbursement request for the carrier or TPA to receive payment by check or electronically.

6. How are "reimbursements" for the purposes of data collection defined? Does it mean the number of services provided for the diagnosis or treatment of autism or does it mean the number of paid claims?

   It means the number of paid claims.

7. Will standard billing codes and descriptions be specified by the department or will carriers or TPAs need to include this information?

   Yes, the department has created Standard Codes and Descriptions for ABA (applied behavioral analysis) as a way to make the processing of such claims more efficient since this is a new benefit. Please note that Carriers and TPAs may use their standard codes and descriptions for other evidence-based treatments and services (i.e. OT, Speech, etc.) for such claims to be considered for reimbursement from the Autism Coverage Fund.

8. Does the department want the claims report as an aggregate or as individual? Is there a template of the data that needs to be provided?

   By individual, please see Claims Data excel spreadsheet for the data information that the carrier or TPA needs to provide. It is recommended that carriers and TPAs download this spreadsheet for use each time claims are submitted to DIFS.

9. Instead of capturing data by county and by age, would the department be okay with carriers or TPAs providing zip codes by providers and date of birth?

   Yes, please refer to the Claims Data excel spreadsheet format for submission of data.

10. Can carriers or TPAs pick who they want to certify the claims report and application request for reimbursement?

    Yes, so long as it is a person who handles claims information and/or financial records for the carrier or TPA. This individual would need to be available to address any questions or concerns relating to the reimbursement request or if audited.

11. To clarify the list of items that are not covered for reimbursement would the following items not be allowed?
    a. Claims for non "evidence based" treatments;
    b. Claims for services (supervision of direct therapy) performed by a nonqualified provider; and
    c. Claims for services provided in the absence of a valid or standard assessment.

    These are examples of the type of claims that will not be reimbursed. However, it will be up to the carrier to make this determination so long as such determinations comply with PA 101 of 2012.

12. Sec. 5(6) of **PA 101 of 2012** states: " If the department determines at the end of the fiscal year that a carrier was not fully reimbursed for paid claims paid due to a shortfall in the reimbursement fund for the fiscal year, and the carrier increases its rates in the following year to cover the total amount of such unreimbursed paid claims, the rate increase shall not be considered reimbursement or compensation for paid claims paid under section 3(n)(*viii*), if the

commissioner determines that such rate increase is a reasonable recoupment of the amount of such unreimbursed paid claims."

In the above statement, what is the definition of "fiscal year" – would this be the state's fiscal year, would the fund run on a fiscal year and that is what is meant, or does this mean the carrier's fiscal year?

Fiscal year refers to the State of Michigan's annual fiscal year which begins, for example, October 1, 2012 and ends September 30, 2013.

13. What's the likelihood of appropriations being made to this fund and if so, what's the anticipated longevity (continued appropriations) of the fund?

    At this time information regarding future appropriations has not been determined. The legislature has appropriated $15 million for the first year of the fund. Should the legislature decide to appropriate additional dollars to this fund it would be on an annual basis from year to year.

14. Is there anything that prohibits a carrier from foregoing to seek a reimbursement from the fund and instead just raising rates to avoid the administrative burden and increase in administrative costs?

    No.

15. Coverage for treatment of ASD may be limited to an insured through 18 years of age and may be subject to a maximum annual benefit of:

    - $50,000.00 through age 6;
    - $40,000.00 from age 7 through age 12; and
    - $30,000.00 from age 13 through age 18.

    Since the above limitations are annual limits and plans will only be reimbursed from the Fund for claims up to these limits, what happens when a child for example, turns 7 in the middle of the year – does that child get a "fresh" maximum of $40,000 even though he/she might have already used the $50,000 maximum? Would the Fund reimburse up to $90,000 for a single individual who changes from one of the age limitations into another sometime in the year? How would this work?

    DIFS recommends that carriers or TPAs use one of three approaches:

    a. **The first is that carriers or TPAs prorate the annual limits in years when a child turns 7 or 13. For example:**
        - **A child who turns 7 on July 1 will have a $25,000 limit from January 1 through June 30, and a $20,000 limit from July 1 through December 31.**

- **A child who turns 7 on April 1 would have a $12,500 limit from January 1 through March 30, and a $30,000 limit from April 1 through December 31. (Calculations may differ depending on whether a carrier prorates by day or by month.)**

b. Alternatively, a carrier or TPA can carry the higher annual limit through to the end of the policy year, if doing so would be administratively simpler. For example:

- **If a child turns 7 on July 1 but the policy renews September 1, then the limit would be $50,000 from September 1 of the previous year through August 31 of the year in which the child turns 7. The annual limit would then be $40,000 starting with the policy renewal.**

c. Finally, a carrier or TPA could establish a system in which the annual limit is based on the age of the child on the date that the plan year begins. For example:

- **If a child is 6 when the plan year begins but turns 7 during the plan year, the benefit for the entire year would be $50,000.**

Using one of these three methods ensures that each child will have the full benefit of the annual limits. It is up to the carriers or TPAs to decide which method works best and DIFS would support any of these methods as acceptable for reimbursement of claims from the Autism Coverage Fund.

Self-Funded Company Questions

1. Are self-funded companies eligible for reimbursement of claims from the Autism Coverage Reimbursement Fund?

   Yes, a self-funded company is defined as a "carrier" under PA 101 of 2012.

2. Can the self-funded company directly submit claims for reimbursement?

   Yes, according to PA 101 of 2012.

3. What is the process for a self-funded company to seek reimbursement from the Fund?

   Self-funded companies need to consider the following:

   a. Requests for reimbursement from the Autism Coverage Fund may come from the self-funded company directly to the state or from its third party administrator (TPA).
   b. Self-funded companies would need to self-adopt the autism benefit and offer to its employees.
   c. Requests for reimbursement from the Autism Coverage Fund can only be applied to the employees who reside in Michigan and also receive treatment from Michigan providers.

- **Claims showing that the treatments were from Indiana, Ohio or outside of Michigan will not be reimbursed from the fund.**

d. If a self-funded company decides to provide coverage that exceeds the age category caps, then it can only get reimbursed up to the age category cap amounts from the fund.

- **Anything in excess of the age category cap amounts would have to be covered by the self-funded company.**

e. If a self-funded company decides to provide coverage that is below the age category cap amounts, then it can still qualify and seek reimbursement from the Autism Coverage Fund.

The process that the self-funded companies would go through in filing a claim directly or by way of its TPA is the same as what any other health insurance carrier would go through to seek a reimbursement from the Autism Coverage Fund.

General Autism Questions

1. Under PA 101 of 2012 for an insurance claim to be reimbursed by the state it looks like ADOS *or* any other results from any other evaluation documentation needs to be provided. Would this mean that the claims for reimbursement for the diagnosis of ASD could be accepted/approved even if ADOS was not used for the diagnosis?

   Yes, if the insurance company allows for the other test. This is up to the insurance companies to determine if they accept other tests.

2. Sec. 416e (6)(b) of **PA 99 of 2012** and Sec. 3406s (7)(b) of PA 100 of 2012 defines ADOS as being the standard for diagnosing autism but that the commissioner could approve other standards. If the commissioner approved other standards besides ADOS, then ADOS would not have to be the only standard followed for diagnosis of autism spectrum disorders (ASD), correct?

   Yes, that is correct. The Commissioner can approve other standards but in the interim DIFS will defer to the response provided above in this section under question 1.

3. Sec. 416e (6)(e) of **PA 99 of 2012** and Sec. 3406s (7)(e) defines the diagnosis of ASD as being assessments, evaluations, or tests, including ADOS.

   Does the word "including" mean in this context as an example such as ADOS? Or does it mean that other assessments or tests can be used but that ADOS has to be included as well?

   ADOS in this section is referenced as one of the tools or as an example.

4. Sec. 416e(6)(d) of **PA 99 of 2012** and Sec. 3406s(7)(d) of **PA 100 of 2012** states: "Behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

(*i*) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
(*ii*) Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

Does DIFS have plans to license/regulate Board Certified Behavior Analysts (BCBA)?

Yes. There are ongoing discussions related to licensing BCBAs but the details are still being worked out and there is an expectation that a proposal will be introduced soon. Since the state does not at this time license BCBA's, under this section treatments need to be *provided or supervised* by a *board certified* behavior analyst or licensed psychologist who is within his/her scope of practice with related training and experience.

5. Will DIFS develop a list of "evidence-based treatment" that falls under this mandate? (Aside from requiring ABA). There are many that are not considered evidence based treatments (i.e. hippo therapy, hyperbaric chamber treatment, etc). Is AVA (Applied Verbal Analysis) covered to the same extent as ABA?

   No, DIFS does not have a list of evidence-based treatments, ABA under the new law is covered and as for the other evidence-based treatments (hippo therapy, hyperbaric chamber treatment, and AVA are not covered) the National Standards Project includes a list of established evidence-based treatments that carriers may want to refer as a guide. Ultimately, the carriers will make the determination.

6. Can you confirm that the school evaluation will not be acceptable for continuation of services? Are the school systems going to stop providing services?

   Evaluations and diagnosis in accordance to the new autism benefit laws need to be done by a licensed physician or a licensed psychologist, so school evaluation is not acceptable for services for reimbursement from the Autism Coverage Fund. Schools under state and federal laws are required to provide educational programs for all special needs children. The intent of the legislation was to help children with autism receive appropriate treatments by trained specialists and medical professionals through early diagnosis and early intervention.

7. Are there limits to the amount of co-pay, coinsurance or deductible a patient can pay?

   The limit on co-pay, coinsurance or deductible cannot be greater than what applies to physical illness generally.

8. What is the actual implementation date of PA 99, PA 100 and PA 101 of 2012?

   The 3 Autism bills were signed into law on April 18, 2012 with an effective date 180 days after enacted into law for policies executed, issued, amended, adjusted or renewed. October 15,

2012 is the effective date for implementation when the carriers are required to offer this benefit.

Plans may offer this benefit at any time should they choose to provide this coverage prior to October 15, 2012. DIFS interprets implementation based on the effective date of the policy, such that the autism benefit would be covered for new policies in effect on or after October 15, 2012. So if a company's enrollment period is prior to October 15, 2012 and the effective date of the policy is prior to October 15, 2012 then the autism coverage may not be offered until the next enrollment period or next effective date of the policy.

15. When is it expected that Medicaid/Medicare eligible individuals will also have this coverage?

Department of Community Health (DCH) is working on this and once DCH receives approval from the federal government of the state's plan is when the autism benefit will be provided.